Mental health policies on reporting child sexual abuse and physician-patient sexual relationships

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The reporting of child sexual abuse (CSA) and physician-patient sexual relationships (PPSR) are currently the focus of professional, legal and media attention in several countries. This paper briefly reviews mental health policies on these issues and reports on a WPA survey of them. While the WPA Madrid Declaration permits breaching confidentiality for mandatory reporting of CSA and clearly prohibits PPSR, it is not known how or to what extent these policies are implemented in WPA Member Societies' countries. It is also not known whether policies or laws exist on these topics nationally or to what extent psychiatrists and the public are aware of them. Representatives of WPA Member Societies were e-mailed a survey about issues pertaining to CSA and PPSR. Fifty-one percent of 109 countries replied. All reporting countries had laws or policies regarding the reporting of CSA, but this was often voluntary (63%) and without protection for reporting psychiatrists either by law (29%) or by Member Societies (27%). A substantial number of psychiatric leaders did not know the law (27%) or their Society's policy (11%) on these matters. With respect to PPSR, some reporting countries lacked laws or policies about PPSR with current (17%) or past (56%) patients. Fewer than half of responding representatives believed that their Society's members or the public were well informed about the laws and policies pertaining to CSA or PPSR. There is clearly a wide range of laws, policies and practices about CSA and PPSR in WPA Member Societies' countries. There is a need in some countries for laws or supplemental policies to facilitate the protection of vulnerable child and adult patients through clear, mandatory reporting policies for CSA and PPSR. Mechanisms to protect and support reporting psychiatrists should also be developed where they do not already exist. There is also a need in some countries to develop strategies to improve the education of psychiatrists, trainees, and the public on these issues.

Key words: Child sexual abuse, psychiatrist-patient sexual relationships, Madrid Declaration

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Ethical standards for psychiatric practice are delineated in the WPA Madrid Declaration and its later supplements (1-3). Two ethical issues, the reporting of child sexual abuse (CSA) and the prohibition of physician-patient sexual relationships (PPSR), have recently been the focus of professional, legal and media attention in several countries (4,5). It is unknown how ethical standards on these two issues are implemented in WPA Member Societies' countries.

There is strong evidence that CSA is harmful to the mental health of children, and this harm may extend into adulthood (6). Many countries mandate the disclosure by health professionals to relevant authorities when CSA is suspected, and failure to report may result in sanctions (7). However, questions arise as to the level of certainty the health professional should have before reporting CSA. The manner in which information about CSA is elicited by the health professional is also contentious, especially if leading suggestions of CSA have been made to the child (8). While the welfare of the child is foremost in psychiatrists' minds, the damage of false CSA allegations to the accused adult are enormous, and must also be considered. Ultimately establishing the veracity of allegations of CSA falls to legal authorities, but psychiatrists may be called as expert witnesses and/or left to treat the child victims, or adult perpetrators.

Increasingly, physicians, including psychiatrists, find that falsely accused adults seek revenge against them through legal channels, or by complaints to medical licensing authorities (4,9). Consequently, CSA reporting to protect their vulnerable child patients may place the reporting physician in jeopardy (9). As a result, paediatricians and psychiatrists are becoming apprehensive about what support they can expect legally and professionally in these precarious situations (9). The WPA Madrid Declaration says little about this issue, but does state that "breach of confidentiality may only be appropriate when required by law (as in obligatory reporting of child abuse or when serious physical or mental harm to the patient or a third party would occur if confidentiality were maintained)" (3).

Sexual relationships between doctors and patients were generally hidden from professional and public gaze until the late 1970s and 1980s, when case reports and surveys began to emerge which suggested that the problem was much larger than previously thought (10,11). Over the next 20 years, the deleterious effects of doctor-patient sex on patients, public trust in physicians, and the offending physician and his family were documented (12,13). While this problem is certainly not unique to physicians, and numerous cases of psychologists, social workers, nurses and non-medical professionals have been reported, it is concerning that the majority of cases against physicians in North America have involved psychiatrists. Policies have been established in many countries and smaller jurisdictions clearly prohibiting sexual behaviour between doctors and patients (14,15).

The WPA Madrid Declaration explicitly states that "under no circumstances should a psychiatrist get involved with a patient in any form of sexual behaviour, irrespective of whether the behaviour is initiated by the patient or the therapist. Consent on the part of a patient is considered vitiated

by the knowledge the psychiatrist possesses about the patient and by the power differential that vests the psychiatrist with special authority over the patient" (1).

This statement is unambiguous with regard to current patients, but silent on relationships with past patients, in which transference issues and power imbalances often, if not always, persist beyond formal treatment (16). In some countries, mental health policies have clearly proscribed sexual relationships between psychiatrists and past patients (14,17), but in other countries mental health policies have remained silent on the whole issue of these relationships with current or past patients.

In an attempt to understand more clearly how WPA Member Societies and the corresponding countries address issues pertaining to CSA and PPSR, we undertook an e-mail survey to: a) assess the presence of national laws and psychiatric societies' policies, including those that could increase the reporting of CSA and protect psychiatrists who reported CSA in good faith, and b) explore the presence of policies that explicitly prohibit PPSR, promote its reporting, and provide treatment for victims and perpetrators. Finally, the survey sought the opinions of national psychiatric leaders about the educational needs of their societies' psychiatrists and the public on these topics.

THE SURVEY

The questions from this 21-question survey were based on the WPA Madrid Declaration and its supplements (1), internationally-respected reports, policies and laws published on these issues (5,7,14,16), and input from the WPA Review Committee. Four questions concerned respondents' demographics, seven questions addressed CSA, and ten questions addressed PPSR. Respondents had the option of completing the survey anonymously by not completing the demographics portion. Respondents could also provide additional anonymous comments.

Representatives of 128 WPA Member Societies (usually the President or Secretary), representing 109 distinct countries, were invited by e-mail to complete the survey. They were also reminded to participate by follow-up e-mails and personally by one of the authors at WPA meetings. If more than one person from a country responded, the respondent's answers that were the most informative, that is, provided the fewest "don't know" responses, were used. The University Health Network Research Ethics Board approved the administration of this survey.

Fifty-six separate countries completed the survey (response rate 51%). The proportion of countries responding from each WPA region was 54% for Europe, 50% for the Americas, 48% for Africa/Middle East, and 35% for Asia/Australasia. Using the World Bank's classification of countries by income, 73.6% of responses came from upper-middle income countries, and 26.4% from lower-middle or low-income countries.

REPORTING OF CHILD SEXUAL ABUSE

Ninety-six percent of responders reported that their country had laws that prevented adults from having sexual relations with minors under a specified age. Of the countries that had laws prohibiting sexual relationships with minors, 7 (13%) did not require health professionals, including psychiatrists, to report knowledge or suspicion of CSA. Of the countries that required reporting of CSA, 8 (15%) did not have laws that penalized persons for not reporting CSA, while an additional 22% of respondents did not know their country's requirement. When asked whether their country's law protected health professionals who reported sexual abuse in good faith if the allegation later proved to be false, 16 respondents (29%) said no and 15 (27%) did not know. Fifteen respondents (27%) reported that their national society did not support psychiatrists who reported CSA in good faith, if the allegation was later shown to be false. Moreover, 6 (11%) did not know their society's policy.

Only 25 representatives (45%) believed that their professional members were well informed about the law and professional requirements on this topic. The public were thought by 18 representatives (33%) to be much less aware about these standards than psychiatrists.

PSYCHIATRIST-PATIENT SEXUAL RELATIONSHIPS

Twenty-eight respondents (52%) reported that their country had laws, and 42 (78%) that their national societies or medical licensing authorities had specific rules prohibiting PPSR with current patients. Only six (11%) representatives' countries and associations did not have either laws and/or policies prohibiting PPSR with current patients, and an additional two (4%) representatives did not know. Thirteen (24%) of the representatives' psychiatric organizations had rules prohibiting PPSR with past psychotherapy patients.

Eleven representatives (21%) reported that their medical licensing authority required one physician to report if another physician was known to be having sex with a current patient. For the countries that had laws or policies prohibiting PPSR with current patients, 26 representatives (57%) reported that psychiatrists lost their licenses to practice if found guilty. For these countries, 13 representatives (50%) were aware of psychiatrists in their association in the last five years losing their licence to practice for this reason. A wide range of time was reported for loss of license, including permanently or discretionary, from one to ten years, depending on the offence. Other sanctions mentioned included death, written reprimands, public reprimands, criminal proceedings, fines, ethics education, professional bad opinion, condemnation, losing job, restrictions on license, supervision and compulsory therapy. Eighteen representatives (18%) reported programs to help physicians disciplined for PPSR, and an equal number reported provision of free counselling to patients of psychiatrists found guilty of sexual misconduct.

Twenty-two representatives (42%) thought their members were well informed about the law and professional standards on PPSR. Of those who thought that their members were not well informed, 19 (86%) believed that education would be useful. Only 11 representatives (21%) perceived that their country's public was well informed on this topic.

DISCUSSION

CSA and PPSR probably occur globally, but the prevalence within many countries is unknown. A Lancet review placed the prevalence of CSA at 2 to 62% in females and 3 to 16% in males, with a wide range of negative physical, social, and psychological consequences for the victims (18). Though studies are more limited on PPSR, one review reported that 7.1 to 10.9% of male psychiatrists and 1.9% to 3.5% of female psychiatrists admitted to intimate sexual contact with current patients (11), with a range of deleterious effects on patients (12).

Most countries and/or WPA Member Societies have laws that prohibit CSA and PPSR with current patients. Basic policies are vital, but enforcement may require supplemental policies to facilitate compliance. This survey revealed that 13% of representatives' countries did not require health professionals to report CSA, and that even in countries that required reporting, several did not have penalties for not reporting. Even countries that have these laws may not enforce them, as one respondent stated: "There are some penalties subscribed in law, but they don't apply in reality. In fact, (these) are just theoretical".

Moreover, psychiatrists may be reluctant to report CSA, especially if they practice in the almost 30% of countries without laws that protect physicians who report it in good faith or if they perceive that their national association will not support them. One respondent wrote: "There is fear among professionals to report sexual abuse because there's no legal or professional protection". Clearly, this has a chilling effect on psychiatrists' abilities to protect their vulnerable child patients.

Suboptimal rates of implementation or supplemental policies were also present for PPSR. One respondent stated "we do not even talk about these things". While 85% of associations had laws or policies prohibiting PPSR with current patients, less than a quarter of representatives reported that their association or medical licensing authority had policies prohibiting PPSR with past psychotherapy patients. This is despite the opinion of many experts on this topic that the nature of the psychotherapy relationship and long lasting effects of transference may always make PPSR with past patients unethical (16). One respondent stated "the psychiatric diagnosis of the patient makes it unlikely she will be believed". Over half the representatives reported that there was not a duty in their country for a physician to report another physician to a medical licensing authority if the latter physician was known to be having a sexual relationship with a patient.

Victims of PPSR suffer many negative health effects, and may require psychotherapy, counselling and other treatment (12). Unfortunately, only a small percentage of representatives reported that their association provided free counselling to patients of psychiatrists found guilty of sexual misconduct or to physicians who are disciplined for engaging in sexual misconduct. One clear finding was that although over half of country representatives reported that, physicians lost their license if found guilty of PPSR, almost half of these representatives were not aware of any psychiatrist in their association losing his or her license to practice for this reason in the previous five years. The wide range of sanctions for PPSR was striking, and ranged from death to education, but loss of license for variable time periods was clearly the most common.

Cultural attitudes toward appropriate boundaries in interpersonal, including professional, relationships likely differ. For example, collectivist cultures (basically Eastern and traditional cultures) and individualist cultures (North America, most of Europe, Australia and New Zealand) may have different views on boundary-keeping practices that affect the psychiatrist-patient relationship (19,20). While some cultural differences are to be expected, what is clear is that all physicians must do no harm, act in the patients' best interests and never exploit patients for their own gratification. Residency training programs and continuing education for clinicians need to include explicit training on PPSR, as suggested by many representatives (13,20).

This study does have some limitations. Responses were received from only 51% of countries, though this rate is greater than in many physician surveys (21). Consequently, the survey may have been subject to responder bias. Responding representatives' associations may have been more likely to be compliant with the Madrid Declaration, and to have broader national policies, as almost three quarters were in countries with greater resources. Social desirability bias may have resulted in more positive responses to questions. Additionally, some representatives may have lacked proficiency in English, which deterred them from responding. Although we assumed that the representatives gave answers that reflected the status of their country and association, it is possible that they were incorrect.

Limitations aside, the results of the survey clearly indicate that problems exist in reporting CSA and in PPSR in several countries. While nearly all the WPA Member Societies have laws or policies for reporting CSA, this practice may be hampered by the voluntary nature of reporting and the lack of legal and professional association support for reporting psychiatrists. The lack of Member Societies' policies and enforcement procedures in some cases indicates the need for further work.

Finally, representatives expressed a need for more education for psychiatrists, trainees, and the public about these issues. One respondent captured this need well: "Since sex in general and professional sexual misconduct in particular is a taboo in this part of the world, patients (mostly women

and minors) need to be empowered to know their rights and be able to bring the perpetrators to justice". We hope that the results of this survey will aid in bringing about necessary changes.

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